United States Agency for International Development
Bureau of Democracy, Conflict and Humanitarian Assistance
Office of Food for Peace

Fiscal Year 2012 Annual Results Report

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Mercy Corps, Guatemala

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LIST OF ACRONYMS

ABKDEC	Baptist Kekchi Cultural Development Association
ADEMAQK	Kajo'om Maya Q'eqchi Development Association
ADS	Automated Directives System
AOTR	Agreement Officer's Technical
ARR	Annual Results Report
AV	Alta Verapaz
BCC	Behavior Change Communication
BL	Baseline
CAFESANO	Northern Coffee Growers Association
CC	Convergence Center
CHC	Community Health Commission
CHF	Community Health Fund
CHV	Community Health Volunteers
COCODE	Community Development Council
CSB	Corn-Soy Blend
CTS	Commodity Tracking System
DIP	Detailed Implementation Plan
EBS	Basic Health Teams (field teams from PSS)
FANTA-3	Food and Nutrition Technical Assistance Project (Phase 3)
FFP	Office of Food for Peace
FFP/M/R	Office of Food for Peace/Mission and/or Regional Office, as appropriate
FFP/W	Office of Food for Peace/Washington
FUNDAMENO	Mennonite Kekchi Foundation in Guatemala
FY	Fiscal Year (October 1st - September 30th)
GIS	Geographical Information System
GOG	Government of Guatemala
HP	Health Post
ICO	Social Cooperation Institute
IFPRI	International Food Policy Research Institute
IPTT	Indicator Performance Tracking Table
IR	Intermediate Result
IS	Institutional Strengthening
ISP	Internet Service Provider
I-STAR	Integrated System for Transformation, Appreciation and Results
ICT	Information and Communication Technologies
IY	Implementation Year (July 1st – June 30th)
KAP	Knowledge, Attitude and Practice
LNS	Lipid-Based Nutrient Supplement
LOA	Life of Award
MC	Mercy Corps
MCG	Mercy Corps Guatemala
MIS	Management Information System
MNP	Micro-nutrient Powder
MOH	Ministry of Health
MOU	Memorandum of Understanding

M&E	Monitoring and Evaluation
MT	Metric Ton
MYAP	Multi-Year Assistance Program
NGO	Non-Governmental Organization
PDA	Personal Digital Assistant
PEC	Coverage Extension Program, MOH
PM2A	Preventing Malnutrition in Children Under Two Approach
PPS	Planning and Performance System
PSS	Decentralized Health Service Providers
PREP	Pipeline and Resource Estimate Proposal
PROCOMIDA	Programa Comunitario Materno Infantil de Diversificación Alimentaria (Mercy Corps' Title II PM2A MYAP in Guatemala)
PROSAN	Food Security Program, MOH
SAM	Severe Acute Malnutrition
SAPQ	Standardized Annual Performance Questionnaire
SESAN	Food Security and Nutrition Secretary
SIAS	Integrated Health Attention Service
SYAP	Single-Year Assistance Programs
TDP	Training and Distribution Points (include CCs and HPs)
TSU	Technical Support Unit
USAID	United States Agency for International Development
XNA IXIM	Multi-Ethnical Women Association

1. Introduction: Annual Food Aid Program Results

This Annual Results Report (ARR) summarizes all activities PROCOMIDA implemented during Implementation Year (IY) 3 (July 2011 to June 2012). In this year the program continued implementation with changes in ration sizes as well as geographical expansion, both approved in advance by USAID/FFP.

Ration sizes were reduced after the program identified leftover rations at household level. The reduction was discussed with IFPRI and FANTA-3 and proposed to USAID/FFP, who approved the change. The reduction was introduced in August 2011.

Table 1. Rations by research arm (program data)

Research Arm	Individual Ration	Family Ration			Total
	CSB	Rice	Beans	Veg Oil	
A (+ Non - Research)	4	6	4	1.85	15.85
B	4	3	3	0.925	10.925
C	4	-	-	-	4.
D + E*	-	6	4	1.85	11.85

** Arms D and E receive Micronutrients (LNS[1] and MNP[2] respectively) as individual ration*

As mentioned in PREP IY3, the program also started expansion in August 2011 to an additional 49 CCs, summing a total of 270 CCs. In January 2012, an additional 14 Health Posts (HP) were added, which sums to a total of 284 Training and Distribution Points (TDP).

Table 2. Geographic coverage (program data)

Municipality		MOH Coverage		PROCOMIDA Coverage					
				IY 2	IY 3			As of end IY3	
		Total CCs	Total Health Posts	CCs in Program	CCs in Program	Health Posts in program	Total TDP	% CCs in program	% Health Posts in program
1	Cahabon	53	1	31	31	1	***32***	58%	100%
2	Cobán	102	6	64	70	6	***76***	69%	100%
3	Lanquín	15	0	15	15	0	***15***	100%	NA
4	San Pedro Carchá	153	5	111	115	5	***120***	75%	100%
5	Senahú	43	2	0	39	2	***41***	91%	100%
TOTAL		**366**	**14**	**221**	**270**	**14**	***284***	**74%**	**100%**

1.1. Beneficiary interventions

[1] Lipid-based Nutrient Supplement
[2] Micro-nutrient Powder

A total of 19,058 mother/child units[3] were active at the end of the IY3, representing a total of 18,450 families. Mother/child units participate for a minimum of six months and a maximum of 30 months (the first 1,000 days approach). To date, an accumulated total of 28,783 families have participated in the program, a vast majority of the beneficiaries being children 6-24 months, as was expected. The percentage of pregnant mothers for 2011 (13.3%) and 2012 (13.1%) suggests that the program has not had an impact on the pregnancy rate (program data).

A total of 188,017 individual rations and 181,400 family rations (rice, pinto beans and vegetable oil) were distributed during IY3. The difference is due to double/multiple individual rations of CSB when there is more than one eligible individual in a family[4].

Table 3: Active beneficiaries by type (as of June 30, 2012)

Beneficiary Type	June 30, 2012
Pregnant women	2,496
Lactating mothers	3,889
Children 6 to 24 months	12,673
Total active beneficiaries	***19,058***
Total Families	18,450
Graduated families	10,333
Accumulative families	**28,783**

Source: PROCOMIDA MIS system

Table 4: Active beneficiaries by region (as of June 30, 2012)

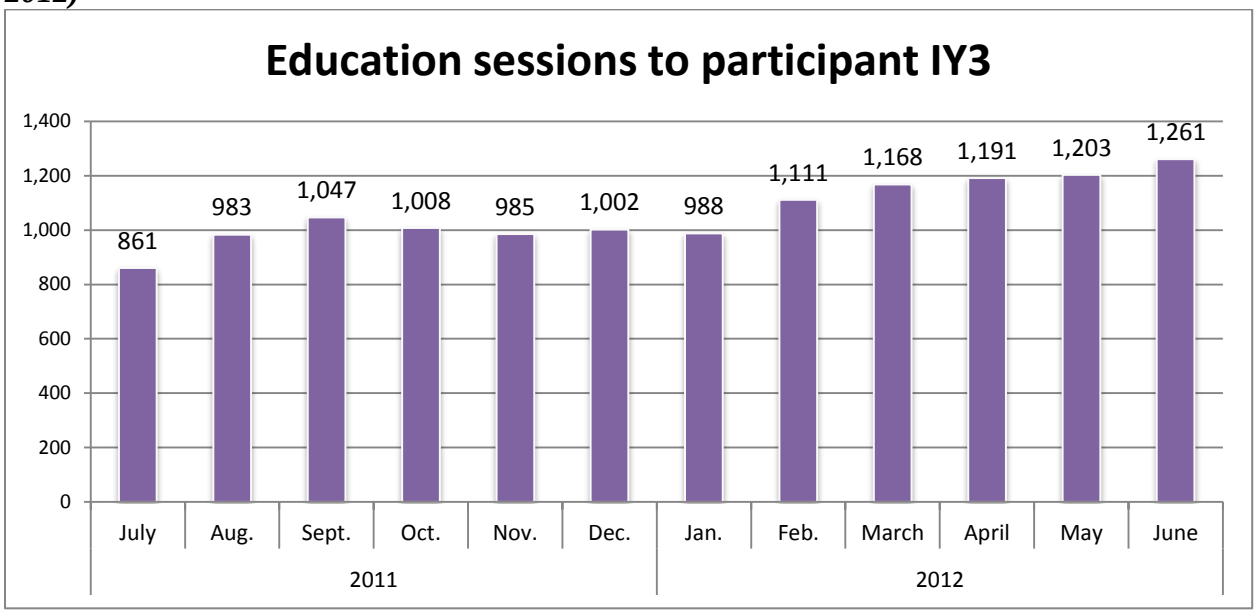
PROCOMIDA Region	Pregnant and Lactating Mothers	Children 6 to 24 month	Total as of June 30, 2012
North Region	2,598	5,361	7,959
Central Region	1,486	2,962	4,448
Western Region	2,301	4,350	6,651
Total	**6,385**	**12,673**	**19,058**

Source: PROCOMIDA MIS system

Beneficiaries have received monthly training from field staff, divided in different groups according to interests (pregnant women, lactating women with children from 0 to 6 months of age and women with children from 6 to 24 months). Specific sessions for sick and/or malnourished children are provided as needed. Field staff has trained an accumulated total of 28,783 families, as well as the health commissions in all 284 TDP. Monthly sessions are held in each CC in the different groups. During IY 3, a total of 12,808 sessions were held.

[3] The program measures its beneficiaries as mother/child units.
[4] e.g.: twins under two year or a child under two years and a pregnant mother.

Image 1: Number of educational sessions implemented to participants (July 2011 – June 2012)



Source: PROCOMIDA monitoring system

Educational sessions include recipe demonstrations with model mothers, who in return replicate them with beneficiaries assigned to them. Through this model, local capacity is increased in adequate diet and food preparation practices, assuring sustainability and program impact.

Field staff has made 10,902 household visits in this year. The local NGO PSS field staff also made 9,348 household visits for a total of 20,250 house visits overall. During the visits stress is given to the importance of assisting the training, strengthens key messages, monitor donated food use, follow up malnourished children and give counseling on nutrition.

In research arms D (LNS) and E (MNP) new beneficiaries continue to receive a trial acceptance test to identify allergies, particularly of the peanut-based LNS, before receiving their first individual ration. For safety reasons, persons with asthma are not receiving LNS.

Institutional Strengthening (MOH, PSS)

1.2. Warehouse

During the third implementation year the program distributed 2,617.9 MT of commodities in the 284 TDP in five municipalities of Alta Verapaz.

Table 5: Distribution Summary by Research Arm (in MT, from July 2011 to June 2012)

Research Arm	CSB	Rice	Beans	Veg oil	Totals
Non – Research	462.42	706.31	470.88	218.83	**1,858.44**
A	55.42	87.38	58.26	25.47	**226.53**
B	52.51	41.40	41.40	12.59	**147.90**
C	33.66	-	-	-	**33.66**
D		93.40	62.26	27.67	**183.33**
E		85.26	56.84	25.95	**168.05**
Totals	***604.02***	***1,013.75***	***689.64***	***310.51***	***2,617.92***

Source: *PROCOMIDA Commodity Status Reports*

The program made three direct distribution call forwards for FY 12 as sufficient stocks were available in warehouse. Mercy Corps tax-free franchise was used for the imports during this period. Commodities were received in seven shipments arriving in Santo Tomas Port for a total of 1,774.956 MT net manifested according the Bill of Ladings as follows:

Table 6: Commodity shipments for IY 3 in MT (direct distribution, dates are arrival at port).

Commodity	CF 1		CF2		CF3			Total
	Shipment 1	Shipment 2	Shipment 3	Shipment 4	Shipment 5	Shipment 6	Shipment 7	
	03/25/12	04/18/12	06/22/12	07/13/12	09/16/12	10/13/12	10/17/12	
CSB	198			199.975		200		597.975
Rice							319.2	319.2
Beans	19.45	199.35	200			288.95		707.75
VegOil					150.031			150.031
TOTAL	**416.8**		**399.975**		**958.181**			**1,774.956**

Source: *PROCOMIDA CTS and Operations Unit*

The clearance process, inland transportation, unloading and return of the empty containers to the port for each shipment was completed within the 45 free-days, as established in the ocean freight contract. The whole process took on average 30 days, with a minimum of 27 and a maximum of 37 days. In this calculation, the days between unloading and fumigation at port are not counted, since that period is responsibility of the carrier as per fright tender. The customs process and port exemption process were completed normally in coordination with USAID, GOG and Port Authorities.

During this implementation year, the program was able to consolidate all commodities to the Coban warehouse, eliminating the need for a warehouse in Zacapa. After toxin contaminated CSB and beans were destroyed as planned, the Zacapa warehouse was closed.

1.3. M&E

During this year, various M&E activities were held. First and foremost, this year the Mid-term evaluation was conducted. An external consultant was hired to do the evaluation. A total of 50 CCs and 1,000 families were interviewed in order to evaluate all indicators and advances in the program. Important lessons have been learned from this process and specific results will be discussed in detail in section 1.4.

Questionnaires were used from the baseline, and some additional questions were added. At beneficiary level, one survey was used, including anthropometric measures of all children under 5 years. At CC level, knowledge interviews were held with Community Health Volunteers (CHV) and a survey on infrastructure, medicines and supplies was held.

The sample was defined in a two staged cluster design. The sampling framework used is:

Cluster Sample Size Calculation

$$n = \left[t^2 \times \frac{p \times q}{d^2}\right] \times DEFF$$

Where:
n = sample size
t = 95% Level of significance (Z=1.96)
p = Expected prevalence (50%)
q = 1- p
d = 5% Error level
DEFF = Design effect (2)

Total sample size was defined at 920 households, which was rounded up to 1,000 households, taking into consideration possible rejects or problems during data collection. With the use of ENA[5] software, cluster size was defined at 50 clusters of 20 households. It was agreed with the consultant that only CCs that were at least ten months present in the program, which are the 270 CCs, excluding the 14 HPs. Clusters were selected through the Probability Proportional to Population method: a list of all 270 CCs with the total of active and graduated beneficiaries was randomly ordered from where the ENA software automatically weights each CC according to number of beneficiary families, thus assuring that each family in each CC has the same probability to be selected. In addition to the 50 CCs selected, an additional six CCs were randomly selected as replacement, in case one of the sample CCs could not be visited in case of security risks or flooding/landslides. In each cluster a total of 20 families were randomly selected from the beneficiary list, with an additional five replacements if a selected family was not present or did not want to answer the survey. Attachment H1 presents the list of CCs selected for the survey.

[5] Emergency Nutrition Assessment for SMART, see http://www.nutrisurvey.net/ena/ena.html

Table 7. Sample cluster distribution by municipality

Municipality	Sample Clusters	Replacement Clusters
Cahabón	4	1
Cobán	14	1
Lanquín	3	0
San Pedro Carchá	22	2
Senahú	7	2
Total	**50**	**6**

Data in the field was collected through tablets and were constantly checked on consistency. Anthropometric data was sent directly to field editors, who checked consistency in the ENA software and returned Z values to the surveyors to be included in the tablet. These Z values were double-checked at data analysis stage. A total of 984 surveys were completed at household level, no replacement CC was needed.

During the last months, the program has recollected all historical growth data of beneficiary children. This was necessary after identifying several weaknesses in the official data collected from the implementing NGOs. From this moment onwards, growth data will be recorded monthly directly from the child's growth charts into the tablets by field staff, during the training sessions. This data will be used immediately to identify if the child is growing well. If there is a delay in growth, CHV will be alerted and mothers will be taken apart for counseling. In the case a child is considered at risk, after the training session its weight and height are measured together with the CHV and entered in ENA or Anthro to identify acute malnutrition. If a child is identified with acute malnutrition, it is immediately referred to the closest health center.

1.4. Program Mid-term Results

Results will be discussed based on the IPTT (see attachment A), ordered by the percentage of target met, with reference to its Intermediate Result (IR). Indicators have been given a unique number throughout the IPTT, in the first column of the table, which is used to guide this discussion. Trigger indicators are discussed separately.

At this point only three changes have been made to the IPTT since the PREP year 4 submission:

- Impact indicator 3 has been changed from % of change in HDDS to: Average HDDS, which is more directly measurable.
- As proposed in IY 2 ARR, Indicator 15 (IR 1.2. Monitoring indicator 9, % of mothers receiving minimum recommended neonatal care) was eliminated, since national standards require the first visit to the mother within three days, which is measured with indicators 16 (IR 1.2. Monitoring indicator 10, % mothers receiving minimum recommended post natal care).
- Indicator 20 refers to CCs has been reformulated to Training and Distribution Points (TDP) to include also the HPs.

A. Indicators that met or exceeded target:

SO 1 Impact indicators

Both Anthropometric Impact Indicators 1 (% children 0 – 59 months underweight < -2 Z score W/A) and 2 (% children 6 – 59 months stunted < -2 Z score H/A) met the target values for the mid-term evaluation. Stunting was targeted for 56.5% and reached 56.1% (101% of target met), while Underweight target was 12% and reached 12.3% (98% of target met). Indicator 3 (% of change in HDDS) target of 6.3 was exceeded by 1.2, which represents an increase of 119%.

IR 1.1.

Indicator 4 (# pregnant and lactating women receiving food rations, accumulative) exceeded the target of 10,000 mothers by 19,989 (200% of target met). Indicator 6 (# children aged 6 – 24 months receiving food rations, accumulative) also exceeded target value of 16,000 by 20,692 children, representing an increase of 129%. As a result of the ration reductions, the program was able to expand its interventions, hence increasing coverage. Indicator 5 (% children 6 – 24 months with minimal acceptable dietary diversity) almost met target of 70% with 63.2% (90% of target met). The program will need to continue to stress the importance of appropriate feeding practices with the mother groups, in order to reach the final target for this indicator.

IR 1.2.

Indicators that are related to knowledge, such as indicators 7 (% caregivers demonstrating increased nutritional knowledge), 10 (% mothers that know the danger signs of pregnancy) and 11 (% mothers with proper identification of childhood illness warning signs) all far exceeded their targets. Indicator 7 reached 45.7% against the target of 10% (457% of target met); Indicator 10 exceeded the target of 20% by 34% (170% of target met); and indicator 11 reached 69.6% while the target was set at 20%. This demonstrates that the program has been able to transfer knowledge to participating mothers. Out year targets will be adjusted accordingly.

Also, more mothers (60.1%) have received minimum post natal care than expected (indicator 16, target 32%, met by 188%), while the percentage of mother that received minimum antenatal care (indicator 14, target 86%) was reached with 85% (99% of target met). Percentage wise, antenatal care (85%) is higher than postnatal care (60%). Hence, the program will promote postnatal care with the health service providers and CHV.

IR 1.3.

The indicator of household action plans (indicator 19) has exceeded the target of 3% by 5.8%, which represents a 193% increase. Indicator 20 (# convergence centers with emergency funds) exceeded the planned 270 CCs with 284, due to the additional HP. Out year targets have been adjusted accordingly, including expansions in IY 4[6].

[6] See IY 4 PREP submission.

SO 2. Impact Indicators

Indicator 22 (% health facilities meeting minimum standards for health and nutrition services and practices almost reached its target of 20% with 19.1% (representing 96% of target met).

Indicator 30 (% of local community health volunteers who meet minimum standards/thresholds for performance) reached exactly the target of 2%. Nevertheless, this indicator should be improved in the following years. The program is involving the CHV in its field activities and at the same time encouraging the NGO Health Implementers to strengthen CHV support.

IR 2.1.

Both indicators 23 (# health commissions with regular meetings) and 24 (#health commissions demonstrating progress on action plans) exceed their target of 270 CCs with 284 (105%), due to the program expansion and inclusion of Health Posts (HP). Health commissions meet monthly with PROCOMIDA staff. They also have twice a year community assemblies to present their progress on their annual work plan to the whole community.

IR 2.2.

Indicator 27 (# health facility staff trained in health and nutrition best practices) target of 60 was exceeded by 121, representing 202% of target met. This is related to both expansion and the inclusion of educators and staff of the health posts.

Indicator 29 (% of detected SAM cases referred per MOH protocols) exceeded the target of 90% by 94%, representing 104% of the target. The remaining 6% was not referred as they did not present complications and were treated in the community.

IR 2.3.

Indicator 31 (# persons trained in planning and advocacy around food security and health) has exceeded the target of 1,680 by 1,988 (118% of target met). This is directly related to the expansion of the program.

B. Indicators that did not meet target:

IR 1.2.

The percentage of newborns who receive essential newborn care (indicator 8) is 70.6%, while the expected target was 80%, thus representing only 88% of the target met. (Awaiting details from MTE report) Likewise, the percentage of children between 0 and 6 months that are exclusively breastfed (indicator 9) is lower than expected: 60.8% versus the target of 75% (81% of target met). This is actually lower than the baseline value of 65%. The methodology of data collection and analysis was reviewed and is comparable to the baseline methods.

Indicators 12 (% children aged 6 – 23 months with diarrhea that received adequate treatment) and 13 (% children aged 6 – 23 months with respiratory diseases that received adequate treatment) are much lower than expected, as they were last year. Indicator 12 reached 27.5%

against the 50% target, which is very similar to baseline value of 26.3%. Indicator 13 reached 39% against the 50% target and is also comparable to the 40.5% baseline value. These indicators depend largely on availability of treatments at MOH facilities.

Likewise, indicators 17 (% children receiving full vaccinations) and 18 (% children receiving routine health services) also did not meet targets due to lack of inventory at health facilities. Indicator 17 reached 50.7% (target was 89%), which is even lower than baseline value of 85.9%. Indicator 18 reached 27.4%, which is higher than baseline value (18.3%), but did not reach target of 45%.

It is important for the program to address these issues with MOH or renegotiate these indicators, since they depend largely on MOH budget.

SO 2. Impact Indicators

Indicator 21 (% health facility staff and community health volunteers able to identify minimum number of core health and nutrition practices) did not reach the target of 20% by far (4.3% reached). This is an important issue and requires attention from the program. At this moment, the program is starting to involve more the community health volunteers (CHV) in our training sessions, in addition to the separate quarterly specific training sessions for CHV. During IY 3, training of the CHV has been focused on improving their growth monitoring practices. For the next year, we will focus more on danger signs. Additionally, the program is currently designing specific training materials for the CHV and traditional midwives that include danger signs and other nutrition practices.

IR 2.1.

The activity related to indicator 25 (# of pregnant women in health facility orientation visits) has not been implemented and the program is considering if it is more effective to take the traditional midwifes of the communities to visit the health facilities, since they play an important role in deciding where women have their deliveries.

Related to this issue, indicator 26 (33.5% deliveries at health facilities, compared to 38% target) has not increased since baseline (35.9%). This may relate to customs and the above mentioned importance of including the traditional midwifes. For this reason, the program is designing training materials for midwifes and training will start in January 2013.

IR 2.2.

Indicator 28 (Availability of a minimal level of infrastructure, supplies and medications at health facilities) is stagnant at 0% since baseline. Again, this is highly dependent of MOH budget and apparently the availability of community health funds to improve CC structure is not enough since it does not affect availability of supplies and medication.

C. Trigger Indicators

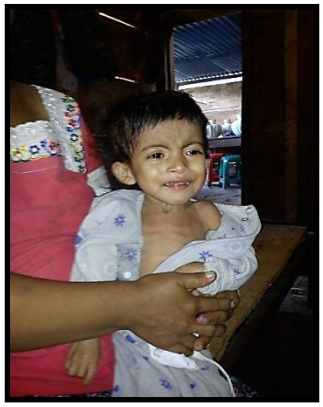
Trigger indicators were measured through secondary data sources, mostly from government institutions, except for indicator 36, Coping Strategies. The latter was measured using the Coping Strategy Index[7] and was measured through the annual household survey. Since trigger indicators are not linked directly to specific program activities, change cannot be attributable. Hence, it is not logical to speak of % target met, but only about levels of risk. Trigger indicators have thus been labeled according to the level of risk: green means no risk; yellow means moderate risk and; red means high risk. It is important to mention that rainfall is marked yellow for two years in a row, last year because of a reduction and this year because of an increase. It has been impossible to collect data on security this year. This information is provided by the Governor of Alta Verapaz, who has not been able to provide crime data.

The coping strategy (indicator 36) has considerably increased this year and is in red. This means people in the intervention area had to implement more strategies to cope with food insecurity, even though they received food rations. Likewise, there is a considerable change in food prices (indicator 33).

[7] Maxwell et al, July 2003. The Coping Strategy Index, Field Methods Manual. Care and World Food Programme.

2. Success story

Little Ana's strong fight for survival



Ana Patricia Tun Xol
Salaguna community, Cobán, A.V.
Guatemala
August 2011 (MCG/PROCOMIDA)

During a PROCOMIDA educational session, on August 2011, mothers enrolled in Salaguna community, 86 kms away from Coban, Alta Verapaz, were concerned about a 2.5 year old neighbor girl, Ana Patricia Tun Xol, who was malnourished. They said that when little Ana was 7 months old, she was abandoned by her mother. Her old grandma took care of her from then on. Participant mothers said that the girl's grandmother, Mrs. Santos Tiul, refused to participate in any of the activities taking place in the community. Due to the extreme poverty in which they lived, the grandmother could not adequately feed little Ana. Moreover the lack of resources, Ana was neglected, and was not accepted by her grandparents nor by other family members, so she used to be separated from the family and rejected by all of them.

PROCOMIDA team made a home visit to Ana's house to verify what was told by the participants in the educational session. Indeed, on August 22, 2011, little Ana was severely malnourished, weighing 12.12 lbs. while the ideal weight for her 2.5 years of age is 27.5 lbs. Although the child was two and half years old, she was immediately enrolled in the program, due to the conditions in which she was found. Also, personalized counseling was given to her grandma to improve child care habits and she was invited to participate in educational sessions and food demonstrations. With the counseling and education sessions, the girl managed to overcome the stage of severe malnutrition and in a month and a half she was moderate malnourished. During the educational session on October 18, 2011, Ana Patricia looked completely different than the day she was found two months before. Grandma Tiul Santos said:

Ana Patricia Tun Xol
Salaguna community, Cobán, A.V.
Guatemala
October 2011 MCG/PROCOMIDA)

"I am wholeheartedly grateful for the visit of PROCOMIDA's field educators to my home, because if it weren't for them, my daughter could have been dead by now. I didn't know how to take care of her, much less how to feed her. I used to give her food that was not suitable (tortrix chips, instant soups and other products with no vitamins). PROCOMIDA taught me that these foods do not contain the necessary nutrients and recommended I would feed her with products harvested in my community together with the food donated by the people of the United States, which, by the way, has been a substantial aid to my finances. The health of my daughter, Ana Patricia, is improving, because she eats much more food now, including CSB. Thanks to PROCOMIDA and to Mercy Corps! I am committed to participate in all sessions and food demonstrations of the program to learn how to prepare food and take care of my family."

Irma Irlanda Tun Cao, Field Educator
PROCOMIDA**,** Mercy Corps Guatemala

Lessons learned

- ✓ There is more transparency and awareness in managing the funds generated by voluntary contributions when health commissions are composed only by women and/or when both women and men participate in the health committee.

- ✓ The Annual Investment Plan for the community health funds assure proper management of these funds, generated by voluntary contributions. It also assures that health commissions respect guidance and restrictions set by the program.

- ✓ To avoid mis-management of the community health funds, generated by voluntary contributions, each health commission plans two community assemblies per year, involving local authorities, where they present expenses and investments, promoting accountability. It is also important for the program to periodically monitor the implementation of the fund, generating investment strategies in health activities to avoid that the amounts of balances grow too high and thus becoming a temptation to take the money for other uses other than those stipulated in the annual investment plans.

- ✓ There is deeper understanding of key messages in the educational sessions developed by field educators when attendee groups do not exceed 20participants.

- ✓ The involvement of officials of the Directorate of Health Area (the Extension of Coverage Unit and Nutrition Unit) in meetings with the coordinators of partner NGOs allows the adoption and implementation of commitments, not only those established in the cooperation agreement with PROCOMIDA but also in other issues related to taking advantage of available resources in the pursuit of sustainability of processes.

- ✓ The programs logistics model, assuring monthly delivery of rations to communities three days before distribution, has ensured compliance with training and distribution schedules and allows dealing with unforeseen events such as: bad roads, bad weather and mechanical failure.

- ✓ Absenteeism to program activities increased in the months when oil is not delivered. Program participants showed more interest in the months that they do receive the four commodities. Consequently, it was decided to rebottle the oil into two-liter bottles as that is the ration size for all participants, except research arm B and C.

- ✓ Continue coordination and communication with partner NGOs is key to portrait the program as a support to current government actions and not as a substitute to MOH's responsibilities.

- ✓ Program's arrival to the municipality of Senahú, encouraged the communities to organize themselves to improve their access roads, thereby ensuring arrival of commodities to the CCs. This indirectly benefited the community in transporting their crops and medical emergencies.

3. Attachments

- **A.** Indicator Performance Tracking Table
- **B.** Detailed Implementation Plan
- **C.** Standardized Annual Performance Questionnaire
- **D.** Tracking Table for Beneficiaries and Resources (Target data for this FY differ from those presented in the PREP due to adjustments in family size, based on actual enrollment data.)
- **E.** Expenditures Report
- **F.** Monetization Tables
- **G.** Supplemental Materials
- **H.** Completeness Checklist